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2. The incentive component basis shall be limited. The incentive component basis shall be 10.5 percent of the lesser of:

   a. the provider's base cost component, or

   b. the incentive base cost limit determined as the lesser of the provider's variable cost limit or the Class I VCL divided by the quantity one plus the support-to-base ratio limit for the provider's bed size group.

3. The Medicaid/Medicare volume incentive portion, available within the provider's variable cost limit, is determined as the volume incentive factor times the appropriate percent of the incentive component basis, for the class.

   Medicaid/Medicare volume is determined as the percentage of Medicare and Medicaid patient days to total patient days. The volume incentive factor is determined from the following table:

Medicaid/Medicare Volume (%) from equal to	to less than	Volume Incentive Factor %
0	10	0
10	20	10
20	40	15
40	50	25
50	60	40
60	70	55
70	80	80
80	100	100

The Medicaid/Medicare percentage is calculated before the beginning of a rate year based upon most recent patient day data and the resulting allowance is paid prospectively. The amount of reimbursement for the Medicaid/Medicare volume incentive is limited by the difference (if any) between the provider's classwide variable cost limit and the provider's variable rate base. Medicaid days are determined from Medicaid paid claims reports with a 270 day cut off period from the provider's base fiscal year. Medicare days are determined from the data submitted on the Medicaid data reporting forms.

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3. The quality of care incentive portion, paid outside the provider's variable cost limit, is determined as the appropriate percent of the incentive component basis for the provider's class times 25 percent times the number of groups in which the quality of care criteria are met. Specificity on the measurement and evaluation of incentive criteria is established in provider publications.

a. Eligibility for meeting the criteria in a particular group is gained by qualifying for at least one of the factors in that group. The groups of factors are:

Group I

- Reduction in decubiti or
- Reducing incidents of injuries to patients

Group II

- Staffing in excess of minimum or
- Continuing education and training

Group III

- Volunteer program or
- Patient council

Group IV

- Absence of specified licensing and certification violations

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b. For "new" owners, who purchase a facility that qualifies for less than two quality of care incentive groups at the time of purchase, the quality of care incentive component will be equal to 50 percent of the quality of care incentive portion if the provider meets the criteria for new owner status. This provision is effective for purchase periods beginning on or after April 1, 1988.

New owner status may be established by request of a purchaser who provides written evidence to prove fulfillment of each of the following requirements: 1) the facility was purchased through a bona fide arm's length transaction; 2) the purchase transaction resulted in the issuance of a new federal employer identification number; and 3) the applicant has been issued a new license by the Michigan Department of Public Health to operate the facility.

4. The Incentive Component is the sum of the volume incentive component and the quality of care incentive component.

E. Excellence Recognition Program

An excellence award program will begin October 1, 1991. Facilities may submit applications documenting the excellence of care provided and innovations in care delivery. Applications will be reviewed by an expert panel. The panel will include representative family members, advocates, providers, and appropriate state agencies. Recognition will be made once a year based on review of submitted applications. A monetary award of up to $10,000 may accompany recognition. The monetary award will not be considered an offset to allowable costs.

F. Husband and Wife Exception

Whenever a husband and wife (or blood relatives) are being cared for in the same facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician in the patient's medical record). If either requires nursing care, the facility will receive reimbursement at the nursing level-of-care rate for both clients. This policy shall be in effect in regard to long-term nursing care and other levels of residential care in facilities with both nursing care and residential units.

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G. Payment Determination for Special LTC Facilities

The payment rates for all special LTC facilities for ventilator-dependent patients shall be a flat per patient day prospective rate determined by the single State agency. The special LTC facility prospective rate shall not be subject to the provisions in Sections IV.A. through IV.F. above, but instead the provisions within this section shall be used for payment determination.

1. Payment shall be made for prior authorized ventilator-dependent patients who have been transferred from an acute care inpatient hospital setting to a qualifying special LTC facility. The prospective rate shall cover care requirements of the patients, including all the costs of benefits associated with Medicare Parts A and B services while the patient resides in the special LTC facility. This includes but is not limited to all routine, ancillary, physician, and other services.

   The purpose of the all-inclusive rate is to provide the facility with payments meant to cover the cost of necessary physician's services including services in the capacity of a case manager who will prescribe and monitor, on a case-by-case basis, habilitative and rehabilitative services. The ultimate goal is deinstitutionalization of those ventilator-dependent patients who may gain an adequate level of independence.

2. Factors used by the single State agency in the determination of the per patient day prospective rate shall include audited costs at facilities providing similar services, expected increases in the appropriate inflationary adjustor over the effective period of the prospective rate, the supply response of providers and the number of patients for whom beds are demanded. The prospective rate will not exceed 85 percent nor fall below 15 percent of an estimate of the average inpatient hospital rate for currently placed acute-care Medicaid patients who are ventilator-dependent. The prospective rate shall be periodically re-evaluated (no more than monthly) to ensure the reasonableness of the rate and that the appropriate balance of supply and demand for special care is met.

3. The cost basis shall be determined in accordance with Section I through III of this plan, excluding Sections III.B, III.C., and III.D. Providers are required to maintain distinct part accounting records for all costs associated with the special LTC beds to ensure those costs are not included as a reimbursement basis in the other distinct parts of the facility.

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H. Payment Determination for Specially Placed Patients

The payment rates for all specially placed patients shall be an individually negotiated per patient day prospective rate determined by the single state agency for a specified period of time (not to exceed 90 days without review). The rate for these patients shall not be subject to the provisions in Sections IV.A. through IV.G. above, but the provisions within this section shall be used for payment determination.

1. Payment shall be made for specially placed patients transferred from an acute-care hospital setting to an approved nursing facility on a prior authorized basis. The purpose of the negotiated rate is to provide reimbursement adequate to meet the unusual needs of this type of patient in a less costly and more appropriate environment than an inpatient hospital setting. The goal of this policy is the most cost effective provision of services needed by the special care patient.

2. Factors used by the single state agency in the determination of the per patient day prospective rate include, but are not limited to: complexity, type of equipment and supplies required, the patient's condition and the market place availability of placement. Any authorized increase in the per diem rate represents the cost of the service. The negotiated prospective rate shall be re-evaluated in consideration of the recipient's needs prior to the last day of the approval period.

3. Providers agree to remove from total costs, a dollar amount equal to the total difference between reimbursement at the special care rate and the established routine Medicaid rate, determined in accordance with other provisions of this plan.

I. Special Dietary Considerations

1. The Program will settle, outside of the 80th percentile Variable Cost Limit actual costs to nonprofit nursing facilities resulting from raw food and food preparation costs associated with special dietary needs for religious reasons.

2. Facilities must apply to receive this special settlement consideration. In applying, facilities must document the reasons for special dietary consideration for religious reasons. The facility also must perform a study to document the increased dietary costs for religious reasons. Once the study is complete, the facility must keep accounting records that allow segregation of that cost differential. Facilities receiving special dietary consideration must perform the study at lease once in the rate year period.

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J. Payment for Variable Costs of Nursing Facilities Under Nursing Home Reform Requirements of Omnibus Budget Reconciliation Act of 1987 (OBRA '87).

1. General Approach: For dates of service on or after October 1, 1990, facility rates will be increased prospectively to cover anticipated costs of meeting the new OBRA '87 requirements. At the end of each facility fiscal year which includes dates of service on or after October 1, 1990, separate reporting of OBRA '87 costs will be required. A settlement of the difference between reported costs and the value of the OBRA '87 rate increment will occur as part of the audit and settlement process. These rate increments will continue outside the general rate setting process until facility fiscal years beginning on or after October 1, 1993, except for Covered Diaper Items for which separate reporting will be discontinued for fiscal years beginning on or after January 1, 1994. (Since nurse aide training and competency testing are considered Medicaid program administrative costs, those costs are reported and settled as a separate reimbursement component and are not included in the provisions of this section.)

2. For Class I and Class III providers, incremental OBRA reimbursement will be paid in the 1993-94 per diem reimbursement rate for those providers who incurred higher costs per day for OBRA costs in 1992-93 compared to 1991-92. The incremental increased cost will be reduced:

   a. by the amount of increase included in the normal rate setting inflation update of the 1991-92 OBRA cost, and

   b. by the amount per day by which the Medicaid variable rate exceeds the variable cost in the 1991-92 rate period.

   The facility specific rate increment will be reimbursed outside the variable cost (80th percentile) ceiling.

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These OBRA rate adjustments will be effective January 1, 1993, through September 30, 1993. Providers with rate years beginning in October, November, and December 1992 will receive an adjustment to cover costs from October 1, 1992, through December 31, 1993. All rate years beginning on or after January 1, 1993, through September 30, 1993, will be paid the add-on for an entire year.

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Eligible providers will be identified as follows:

a. Initially, a study of 1992-93 interim OBRA reimbursement data will identify providers eligible for the extended rate add-on. Submitted\interim cost data used in the study will be replaced by subsequent submitted\audited cost data for the target time period.

b. At the time of settling fiscal years 1992-93, each provider will be reviewed for possible extended OBRA reimbursement.

3. Allowable costs: Allowable OBRA '87 costs include, but are not limited to, the increased staffing costs (including overtime) and consultant costs to meet the following requirements:

a. RN coverage for seven days per week;
b. Medical director (new cost or increased cost due to OBRA '87 requirements);
c. Bachelor's degree social worker;
d. Resident assessment;
e. Nurse aide in-service training;
f. Psychopharmacological drug review, drug holidays, and self-administration of drugs; and
g. Other documentable costs (such as activities director or medical records staff).

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K. Inflationary Adjustment Through Wage Pass-Through for Class I and Class III Facilities

For rate years beginning on or after October 1, 1999, a wage pass-through program will be available to all Class I and Class III nursing facilities. The wage pass-through program directs an inflationary adjustor to wages of nursing facility employees. A zero percent (0%) historical inflationary adjustor and a four percent (4%) prospective inflationary rate will be directed to employee wages. The computation of the Variable cost limit uses a zero percent (0%) historical inflationary adjustor and four percent (4%) for the prospective inflationary adjustor. The pass-through is settled outside of the 80th percentile Variable Cost Limit.

The wage pass-through program provides up to $.75 per hour for any Class I or III nursing facility employees. Employees subject to the Owner/Administrator Compensation Limits are eligible only if the facility is below the limit. Facilities submit estimates of cost to the Department on prescribed forms. Information from these forms is used to compute an interim rate add-on to provide the Medicaid share of cash flow to facilities granting eligible increases. Upon completion of a facility fiscal year, settlement of the Medicaid share of actual expenditures related to the eligible wage and benefits increases occurs.

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If the accumulated rate add-on is less, settlement up to the amount occurs. If the accumulated rate add-on exceeds the Medicaid shore of the actual expenditures, hte difference is recovered. If the accumulated rate add-on exceeds the Medicaid share of actual expenditures by more than 5%, a 10% penalty will also be asssessed on the difference. The penalty is the amount in excess of 5%, multiplied by the 10% penalty factor. The penalty is applied at settlement for the entire cost period. In subsequent years the rate add-on will be continued in lieu of half of the historical inflatgionary adjustor. The add-on will be adjusted to the settlement amount.

M. Payment Determination for Hospitals Providing Short Term Nursing Care (Swing Beds).

The payment for hospital swing bed services shall be a flat per patient day prospective rate determined by the Medical Services Administration. The following shall be used for payment determination.

1. The amount of payment is the weighted statewide routine nursing care per diem rate for the previous calendar year. The average nursing home per diem rate is calculated by dividing the sum of the Medicaid Class I and Class III amount approved for payment for routine nursing care days by the Medical Services Administration, by the sum of nursing care days paid for the previous calendar year.

2. Payment will not be made for swing bed days which occur before the combined length of stay in the acute care hospital bed and the hospital swing bed exceeds the average length of stay for the Medicaid diagnosis related group (DRG) for the admission.

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N. Long Term Care Facility Proportionate Share Pool

A proportionate share pool is created each fiscal year to increase reimbursement to providers. Eligible providers are those owned by local units of government and in operation at the time of payment. Payment to each facility is in proportion to the facility's number of Medicaid Program inpatient days for the most recent completed calendar year. The inpatient days will be determined from the Medicaid Program Invoice Processing payment data nine months after the end of the calendar year. The pool is created each state fiscal year subject to the availability of funds and the upper payment limits of 42 CFR 447.272. The pool will be funded at a level not to exceed the Medicare upper payment limit for each state fiscal year, which ends September 30. A public notice will be distributed that provides information about what the payments will be each year. The information will comply with applicable federal public notice standards for each year.

O. Personal Clothing for Recipients in Class IV Intermediate Care Facilities for the Mentally Retarded (ICF/MR)

Class IV facilities are reimbursed for allowable costs determined in accordance with the Medicare Principles of Reimbursement (42 CFR, Chapter IV, Subchapter B, Part 413), with the following additions:

To enable the normalization of recipients in ICFs/MR, street clothing supplied by the facility and/or required by the patient's plan of care will be considered an allowable cost for Medicaid patients residing in ICFs/MR who do not own or have other access to the clothing required.